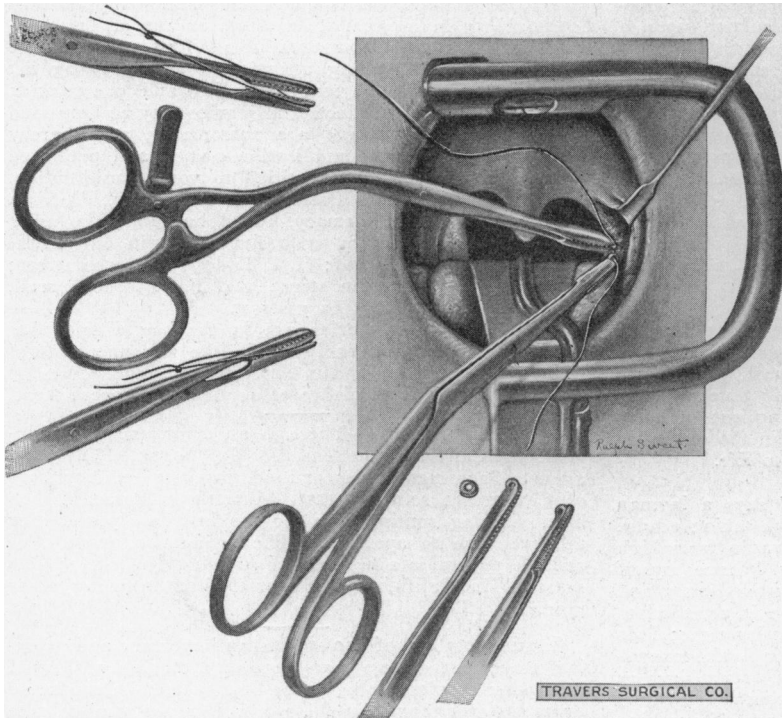


Clinical Notes, Suggestions and New Instruments

TONSIL LIGATING INSTRUMENTS

This set of instruments, devised and improved by Doctor C. R. Bricca of San Francisco, consists of two forceps and mouth gag (Davis). The forceps, as illustrated, are an angle-bent haemostat, which carries a looped ligature with a single knot, so that when any vessel is seized the ligature encircling the vessel enables the operator to tie the same, visibly, by aid of the forceps with a ring on the upper blade. One end of the ligature is passed



through the ring, and by pushing the knot over the end of the haemostat and with gentle traction on the other strand the knot is easily completed.

These instruments eliminate the use of all needles and traumatizing haemostats, and also the tying of the pillars together. The instruments being angle-bent, allow the operator an unobstructed view of the surgical field, and the hands of the operator are outside the visual line. Any size blood vessel can be visibly ligated with these instruments, regardless of location.

These instruments are manufactured and distributed by the Travers Surgical Company, San Francisco.

PERFORATIONS OF STOMACH AND DUODENUM DUE TO ULCERS

Comment by Ralph Van Vranken, M. D.,
Los Angeles, Calif.

There is probably no surgical condition that has been more often discussed or results that have been more often fatal than perforations of the gastro-intestinal tract. Early diagnosis followed by immediate surgery is, without doubt, the most adequate method to lower the mortality.

In all perforations of the gastro-intestinal tract it is of the greatest importance that the site of the perforation be determined prior to surgical interference. Too often an incision is made in the lower abdomen, expecting to find an appendix as the seat of the trouble when in reality the stomach is the focus of the condition. The increased hauling around of the viscera and contamination due to such an error is often most telling on the patient, say nothing of the embarrassment to the occasional individual that operates for an acute appendix,

sends patient back to bed, and in the morning, when the autopsy is done, the pathologist finds a perforation of the stomach.

It is with this in mind that I wish to bring out a few cardinal points that help to differentiate this condition from other acute conditions of the abdomen. The following points I have observed from about six or seven perforated cases that I have seen in the last few years.

The patients were usually about middle age. All the cases that I have seen have been men. The patients were thin, emaciated, and in a condition of severe shock. They usually gave a history of previous stomach trouble of possibly years' duration. Soda bicarbonate had previously given relief. The present trouble struck them suddenly like a knife going through them. The cases were all pictures of acute peritonitis and, if seen early, the pain was more noticeable on palpation at the pit of the stomach or over the area of the perforation. The usual case was sweating when seen, or had sweated rather profusely before. Quite frequently there was pain in the right shoulder. One case seen, this was the main complaint of the patient. Hiccough, vomiting, and markedly rapid respiration was noticeable separately or in combination in about one-half of the cases.

The temperature was usually close to normal or slightly subnormal. The pulse was rapid and thready. The blood pressure showed a decrease. It is of significance that the blood picture shows little variance from normal, save there being a slight decrease in R. B. C. and hemoglobin. The urine often showed a trace of albumin and acetone.

These cases were operated on by an incision above the navel, in the mid-line. The sight of the perforation was readily accessible in all cases, except one which was in the posterior part of the duodenum. The holes were purse-stringed and then lapped over, drains inserted under the liver, another one in the midregion, and a third drain was brought up through a stab wound just above the bladder.

Patients were put to bed in Fowler position and given nothing by mouth for three days except a mouth wash, which was given the patient from the start. Normal saline was given under the skin, about 1000 cc. every eight hours, and drop method by rectum continuously until the third day, when Sippy treatment was started.

Five patients left the hospital alive and one died. This one was operated on about twenty-four hours after rupture, the others from six to eighteen.

As a summary, I might say that patients with perforations of the stomach or duodenum should be operated on as soon as a diagnosis is made. It is very hard to differentiate between perforations of stomach and duodenum. The abdomen should be opened above the umbilicus, so as to avoid undue handling and contamination. Cases of acute peritonitis that give a history of acute onset where pain is or was greatest in the abdomen above the umbilicus, where there is hiccough, pain in the shoulder or rapid respiration, where the temperature is practically normal, and the blood picture shows little variance from normal are usually perforated stomachs or duodenal ulcers and should be treated as such.

1039 East Vernon Avenue.

Medicine being a science of man, for man, and by man, must be learned from man through a study of man to a large though varying degree. The evil that holds modern medical education in its grip is too much theory and not enough practice; too much talk about the bedside and not enough sitting by it.—*Illinois Medical Journal*.

A great physician long ago said that a scientist who could not make any scientific fact clear to any intelligent person did not know his fact or it was not a fact.